SERFF Tracking Number:	*MUTM-126989770*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*48124*
Company Tracking Number:	*SOFIA KUEHN*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.012 Multi-Plan 2010*
Product Name:	*Med Supp Transformed App-United - UA5978-03*		
Project Name/Number:	*Med Supp Transformed App-United/UA5978-03*		

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Med Supp Transformed App-United - UA5978-03	SERFF Tr Num: MUTM-126989770	State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 48124
Sub-TOI: MS08I.012 Multi-Plan 2010	Co Tr Num: SOFIA KUEHN	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Authors: Mary Cleasby, Shelly Kaipust, Sofia Kuehn, Jan Serafini, Thea Shepherd, Mary Gregg, Jaime Mosqueda, Gilbert Burket, Krysia Gannon, Ellen Cochrane, Melanie Worth, Robyn Gonzales, Joanne Najdzin, Kristin Miller, Luther Mardock, Neil Sandhoefner, Shirley McPhaull, Katie Tupper	Disposition Date: 03/09/2011
	Date Submitted: 03/01/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: Med Supp Transformed App-United	Status of Filing in Domicile:
Project Number: UA5978-03	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 03/09/2011
	State Status Changed: 03/09/2011
Deemer Date:	Created By: Ellen Cochrane
Submitted By: Ellen Cochrane	Corresponding Filing Tracking Number:

SERFF Tracking Number:	*MUTM-126989770*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*48124*
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Product Name:	*Med Supp Transformed App-United - UA5978-03*		
Project Name/Number:	*Med Supp Transformed App-United/UA5978-03*		

Filing Description:

RE: United of Omaha Life Insurance Company
NAIC # 261-69868 FEIN 47-0322111
Individual Medicare Supplement Insurance
Application UA5978-03

Attached for filing with your department is Application UA5978-03, which will be used to apply for all of our modernized 2010 Medicare supplement policies. This application is new and will replace application UA5910-03 Rev, previously approved on January 12, 2011. Application UA5978-03 will be used by our agency/brokerage and direct response distribution channels.

This new application was designed as a key component of our new business transformation project which will improve the overall efficiency of our application and underwriting processes. One new optional feature of this application is the applicant's ability to choose to receive electronic Explanation of Benefit statements. We request the use of electronic signature capabilities with this application.

A Memorandum of Variable Material is attached which describes all variable aspects of this application.

The Flesch score for this application is 53.2, when scored with the policy with which it will be used.

Please note, we are simultaneously submitting similar filings under separate SERFF tracking numbers for other companies for whom our affiliate, Mutual of Omaha Insurance Company, administers Medicare supplement business.

Your consideration and approval of this filing will be most appreciated. If I may be of additional assistance as you complete your review, please do not hesitate to contact me.

Sincerely,

Sofia Kuehn, HIA, ACS, AIRC, AIAA
Senior Product and Advertising Compliance Analyst
Corporate Compliance and Ethics
Phone: 402-351-8498
Fax: 402-351-5298
E-mail: sofia.kuehn@mutualofomaha.com

SERFF Tracking Number:	*MUTM-126989770*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*48124*
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TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.012 Multi-Plan 2010*
Product Name:	*Med Supp Transformed App-United - UA5978-03*		
Project Name/Number:	*Med Supp Transformed App-United/UA5978-03*		

Company and Contact

Filing Contact Information

Sofia Kuehn, Senior Policy Drafting and Regulatory Specialist	sofia.kuehn@mutualofomaha.com
Mutual of Omaha	402-351-8498 [Phone]
Mutual of Omaha Plaza	402-351-5298 [FAX]
Omaha, NE 68175	

Filing Company Information

United of Omaha Life Insurance Company	CoCode: 69868	State of Domicile: Nebraska
Mutual of Omaha Plaza	Group Code: 261	Company Type: Life Insurance
Omaha, NE 68175	Group Name:	State ID Number:
(402) 351-6910 ext. [Phone]	FEIN Number: 47-0322111	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	$50.00	03/01/2011	45153283

SERFF Tracking Number:	*MUTM-126989770*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*48124*
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Project Name/Number:	*Med Supp Transformed App-United/UA5978-03*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	03/09/2011	03/09/2011

SERFF Tracking Number:	*MUTM-126989770*	*State:*	*Arkansas*
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Disposition

Disposition Date: 03/09/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MUTM-126989770*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*48124*
Company Tracking Number:	*SOFIA KUEHN*		
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Memorandum of Variable Material	Approved	Yes
Supporting Document	AR Credit Card Cert	Approved	Yes
Form	Individual Medicare Supplement Insurance Application	Approved	Yes

SERFF Tracking Number:	*MUTM-126989770*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*48124*
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Project Name/Number:	*Med Supp Transformed App-United/UA5978-03*		

Form Schedule

Lead Form Number: UA5978-03

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 03/09/2011	UA5978-03	Application/ Enrollment Form	Individual Medicare Supplement Insurance Application	Initial		53.200	UA5978-03 (AR).pdf

1.

Agent Writing #	Group # (if applicable)	Keyline

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Application for Medicare Supplement Coverage

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided may be viewed or shared with the other applicant.

2.

A. Plan Information (to be completed by Producer)

Applicant A	Applicant B
Plan (select one) ☐ Plan A ☐ Plan F ☐ Plan G ☐ Plan M ☐ Plan N	**Plan (select one)** ☐ Plan A ☐ Plan F ☐ Plan G ☐ Plan M ☐ Plan N
Requested Effective Date	**Requested Effective Date**
2a. **Deliver Policy to** Applicant A ☐ Producer ☐ **Delivery Method** Mail ☐ E-mail ☐	**Deliver Policy to** Applicant B ☐ Producer ☐ **Delivery Method** Mail ☐ E-mail ☐

3.

A. Plan Information

Applicant A	Applicant B
Check the Plan You Prefer: ☐ Plan A – UM20 ☐ Plan F – UM23 ☐ Plan G – UM24 ☐ Plan M – UM30 ☐ Plan N – UM31	**Check the Plan You Prefer:** ☐ Plan A – UM20 ☐ Plan F – UM23 ☐ Plan G – UM24 ☐ Plan M – UM30 ☐ Plan N – UM31
Requested Effective Date / /	Requested Effective Date / /

Reply-by-Date

Keyline _____

Name _____

Mailing Address _____

_____

City _____ State _____

ZIP _____

If the above address is not your residence address, please state correct address _____

_____

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B. Applicant Information

Applicant A	Applicant B
Name (First/Middle/Last)	Name (First/Middle/Last)
4. Residence Address	Residence Address (if different from Applicant's)
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone (_____)_____ (area code)	Home Phone (_____)_____ (area code)
E-mail Address	E-mail Address
Current Age _____ Date of Birth _____ / _____ / _____ mo day yr	Current Age _____ Date of Birth _____ / _____ / _____ mo day yr
☐ Male ☐ Female	☐ Male ☐ Female
Social Security #	Social Security #
Height Weight Ft _____ In _____ Lbs _____	Height Weight Ft _____ In _____ Lbs _____

5. **Go paperless!** To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from United of Omaha.

Applicant A	Applicant B
Receive statement online? ..... ☐ Y ☐ N	Receive statement online? ..... ☐ Y ☐ N

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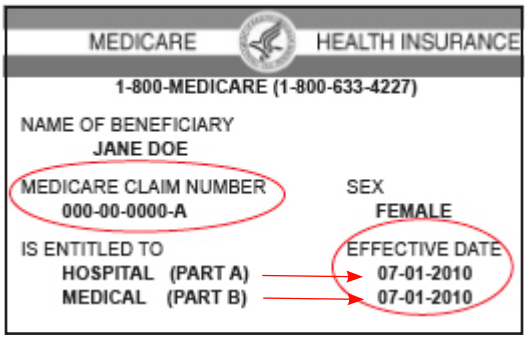
C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	Applicant B
Medicare Claim Number	Medicare Claim Number
Medicare Part A Effective Date _____ / _____ / _____ If you are not covered under Medicare Part A, what is your eligibility date _____ / _____ / _____	Medicare Part A Effective Date _____ / _____ / _____ If you are not covered under Medicare Part A, what is your eligibility date _____ / _____ / _____
Medicare Part B Effective Date _____ / _____ / _____ If you are not covered under Medicare Part B, indicate the date you plan to enroll _____ / _____ / _____	Medicare Part B Effective Date _____ / _____ / _____ If you are not covered under Medicare Part B, indicate the date you plan to enroll _____ / _____ / _____

D. Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.	**Applicant A**	**Applicant B**
1. Does a member of your household: (a) with whom you have continuously resided for the last 12 months; or (b) to whom you are married either have an existing Medicare supplement plan with, or are applying for coverage with United of Omaha Life Insurance Company, United World Life Insurance Company or Mutual of Omaha Insurance Company?.....	☐ Y ☐ N	☐ Y ☐ N

2. If you answered "YES" to Question 1 above, please fill out the following information, except if both applicants are both applying for coverage on this application.

Name (First/Middle/Last)
Policy Number
Street Address
City/State/ZIP

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E. Previous or Existing Coverage Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. **Please include a copy of the notice from your prior insurer with your application.** PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge and Belief:	**Applicant A**	**Applicant B**
3. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....	☐ Y ☐ N	☐ Y ☐ N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	☐ Y ☐ N	☐ Y ☐ N
Please answer questions regarding another Medicare supplement or Select plan:		
4. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....	☐ Y ☐ N	☐ Y ☐ N

(b) Indicate planned termination or disenrollment date.
Applicant A _____ / _____ / _____
Applicant B _____ / _____ / _____

(c) With what company, and what plan do you have?

Applicant A	**Applicant B**
Name of Company	Name of Company
Plan	Plan

Please answer questions regarding Medicare plan coverage (other than Medicare supplement):		
5. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this previous or existing coverage:		

(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
Applicant A START _____ / _____ / _____ END _____ / _____ / _____
Applicant B START _____ / _____ / _____ END _____ / _____ / _____

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	Applicant A	Applicant B
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....	☐ Y ☐ N	☐ Y ☐ N
(c) Planned date of termination/disenrollment? Applicant A _____ / _____ / _____ Applicant B _____ / _____ / _____		
(d) Was this your first time in this type of Medicare plan?.....	☐ Y ☐ N	☐ Y ☐ N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....	☐ Y ☐ N	☐ Y ☐ N
(f) Did you drop a union group or employer health plan to enroll in this Medicare plan?..	☐ Y ☐ N	☐ Y ☐ N
(g) Please indicate reason for termination/disenrollment:	**Check box(s) below if applicable**	
■ Your Medicare Advantage plan is leaving the Medicare program.....	☐	☐
■ Your Medicare Advantage organization stopped offering Medicare Advantage plans.....	☐	☐
■ Your Medicare Advantage organization stopped offering coverage in the area in which you live.....	☐	☐
■ You moved out of the geographic service area of your Medicare Advantage plan.....	☐	☐
■ You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan.....	☐	☐
■ Other: _____ Applicant A _____ Applicant B		

Please answer questions regarding other health insurance:		
6. Have you had coverage under any other health insurance within the past 63 days?..... (For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this previous or existing coverage:		
(a) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank. Applicant A START _____ / _____ / _____ END _____ / _____ / _____ Applicant B START _____ / _____ / _____ END _____ / _____ / _____		
(b) Planned date of termination/disenrollment? Applicant A _____ / _____ / _____ Applicant B _____ / _____ / _____		
(c) With what company and what kind of policy/certificate? (List below.)		

Applicant A	**Applicant B**
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type

F. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
6. 7. Are you applying during a guaranteed issue period?..... (NOTE: [Refer to the guaranteed issue worksheet to help identify if you are eligible.] If the answer above is "YES," attach proof of eligibility.)	☐ Y ☐ N	☐ Y ☐ N
8. Did you turn age 65 in the last six months?.....	☐ Y ☐ N	☐ Y ☐ N
9. Did you enroll in Medicare Part B in the last six months?..... **If "YES," indicate your effective date.** Applicant A _____ / _____ / _____ Applicant B _____ / _____ / _____	☐ Y ☐ N	☐ Y ☐ N

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7a. STOP **IF EITHER YOU OR APPLICANT B ANSWERED "YES" TO QUESTION 7 OR BOTH QUESTIONS 8 AND 9 IN SECTION F, SKIP SECTIONS G & H AND GO TO SECTION I.**

If you are applying during an open enrollment or guaranteed issue period: SKIP SECTIONS G & H and GO TO SECTION I.

[(Please see the enclosed material for explanation of the open enrollment and guaranteed Issue periods.)]

G. Health Information

7c. **For all plans, answer questions 10-21. (EXCEPTION – If applying for Plan N and replacing a Medicare supplement, Medicare Advantage or employer group health plan, ANSWER ONLY QUESTIONS 10-14.)**

(If "YES" is answered to any of the following questions 10-20, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
10. Are you currently confined to a wheelchair or any motorized mobility device?	☐Y ☐N	☐Y ☐N
11. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility where you receive skilled nursing care, or receiving any occupational or physical therapy?	☐Y ☐N	☐Y ☐N
12. At any time have you been diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	☐Y ☐N	☐Y ☐N
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	☐Y ☐N	☐Y ☐N
13. Within the past two years have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	☐Y ☐N	☐Y ☐N
B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?	☐Y ☐N	☐Y ☐N
14. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing or any surgery that has not been performed?	☐Y ☐N	☐Y ☐N
Do not proceed if applying for Plan N and are replacing other coverage		
15. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Alzheimer's Disease, dementia or any other cognitive disorder?	☐Y ☐N	☐Y ☐N
B. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?	☐Y ☐N	☐Y ☐N
C. Systemic Lupus or Myasthenia Gravis?	☐Y ☐N	☐Y ☐N
D. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐Y ☐N	☐Y ☐N
E. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	☐Y ☐N	☐Y ☐N
F. Chronic hepatitis or cirrhosis?	☐Y ☐N	☐Y ☐N
G. Osteoporosis with fractures?	☐Y ☐N	☐Y ☐N
16. Do you have diabetes with complications including retinopathy, neuropathy, peripheral vascular disease, any related heart disorder (Including hypertension/high blood pressure) or kidney disease?	☐Y ☐N	☐Y ☐N
17. Do you have an implanted cardiac defibrillator?	☐Y ☐N	☐Y ☐N
18. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Alcoholism or drug abuse?	☐Y ☐N	☐Y ☐N
B. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	☐Y ☐N	☐Y ☐N
C. Internal cancer, lymphoma or melanoma?	☐Y ☐N	☐Y ☐N
D. A stroke or transient ischemic attack (TIA)?	☐Y ☐N	☐Y ☐N
E. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?	☐Y ☐N	☐Y ☐N
19. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	☐Y ☐N	☐Y ☐N
20. Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐Y ☐N	☐Y ☐N
21. Have you used tobacco in any form in the past 12 months?	☐Y ☐N	☐Y ☐N

7b.

7c.

STOP

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H. Medication Information

7b. **If you are applying for ANY plan OUTSIDE of an open enrollment or guaranteed issue period, please list all over-the-counter or prescription medications you have taken in the past 24 months in the table below.**

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

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I. Agreement and Authorization

IMPORTANT STATEMENTS

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO UNITED OF OMAHA LIFE INSURANCE COMPANY

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to United of Omaha. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, United of Omaha Life Insurance Company, [P.O. Box 3608, Omaha, NE 68103-3608]. I realize that my right to revoke this authorization is limited to the extent that United of Omaha has taken action in reliance on the authorization or the law allows United of Omaha to contest the issuance of the policy or a claim under the policy.
- "Personal Information" means all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by United of Omaha.

8. I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** and an Outline of Coverage.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement is guilty of insurance fraud.

9a. Applicant A's Signature _____ Date _____ / _____ / _____ (mo / day / yr)

Applicant B's Signature _____ Date _____ / _____ / _____ (mo / day / yr)

9b. Dated at _____ (City) _____ (State), on _____ (Month) _____ (Day), _____ (Year) _____ (Applicant A's Signature)

Dated at _____ (City) _____ (State), on _____ (Month) _____ (Day), _____ (Year) _____ (Applicant B's Signature (if applying))

UA5978-03

10.

J. Producer Comments (please attach a separate sheet if needed)

11.

K. To be Completed by Producer

22. Producers shall list any other health insurance policies/certificates they have sold to the applicant.
(a) List policies/certificates sold to the applicant which are still in force.

Applicant A
Applicant B

(b) List policies/certificates sold to the applicant in the past five (5) years which are no longer in force.

Applicant A
Applicant B

I/We certify as follows:

I/We have provided a copy of the replacement notice if the applicant is replacing coverage..... ☐ Y ☐ N
I/We have accurately recorded in the application the information supplied by the applicant..... ☐ Y ☐ N
I/We certify that we have interviewed the proposed applicant..... ☐ Y ☐ N

If you answered "NO" to any of the above statements, please explain why. _____

_____

✍ _____		✍ _____	
Signature of Licensed Producer	Date	Signature of Licensed Producer	Date
_____	_____	_____	_____
Printed Name	Agent Writing Number	Printed Name	Agent Writing Number

UA5978-03

SERFF Tracking Number:	*MUTM-126989770*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*48124*
Company Tracking Number:	*SOFIA KUEHN*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.012 Multi-Plan 2010*
Product Name:	*Med Supp Transformed App-United - UA5978-03*		
Project Name/Number:	*Med Supp Transformed App-United/UA5978-03*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification — Approved — 03/09/2011

Comments:

Attachment:

AR Read Cert.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Application is attached under the Form Schedule Tab.

Item Status: **Status Date:**

Bypassed - Item: Health - Actuarial Justification

Bypass Reason: Not required for this filing

Comments:

Item Status: **Status Date:**

Bypassed - Item: Outline of Coverage

Bypass Reason: Not required for this filing.

Comments:

Item Status: **Status Date:**

Satisfied - Item: Memorandum of Variable Material — Approved — 03/09/2011

Comments:

Attachment:

UA5978-03 MOV (AR).pdf

SERFF Tracking Number:	*MUTM-126989770*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*48124*
Company Tracking Number:	*SOFIA KUEHN*		
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Product Name:	*Med Supp Transformed App-United - UA5978-03*		
Project Name/Number:	*Med Supp Transformed App-United/UA5978-03*		

		Item Status:	**Status Date:**
Satisfied - Item:	AR Credit Card Cert	Approved	03/09/2011

Comments:

Attachment:

AR Credit Card Cert.pdf

ARKANSAS

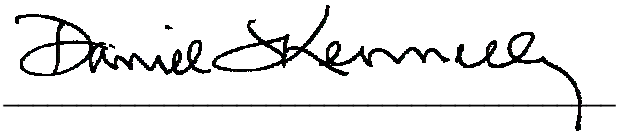
CERTIFICATION

This is to certify that the attached form(s) has/have achieved the following Flesch Reading Ease Score(s) and complies/comply with the requirements of Ark. Stat. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form	Description	Score
UA5978-03	Individual Medicare Supplement Insurance Application	53.2*

*This score was achieved by removing language or terminology entitled to be excepted by your state's readability regulation.

Date: March 1, 2011



Daniel J. Kennelly
VP, Chief Compliance and Ethics Officer

Memorandum of Variability
Explanation of Variable Statements and Fields
For United of Omaha Life Insurance Company
Application Form UA5978-03

Each variable section, statement or field is denoted by [brackets] and annotated with numbers in RED. The explanations below follow the order in which the variable fields appear in the form. Address/PO Box should be considered variable to accommodate an address change, in which case the department will be notified.

Variable Statements/Fields	*How or When Used*
1. [Agent Writing # Group # (if applicable) Keyline]	Will display or remove these administrative fields on the applications based on distribution type.
2. [A. Plan Information (to be completed by Producer)….] 2a. [**Deliver Policy To** **Delivery Method** Applicant A ☐ Producer ☐ Mail☐ E-mail☐]	2. Section will display on applications used by our Agency and Brokerage distributions, and will be removed for our Direct-to-Consumer distributions. The Medicare supplement plans available will be displayed. 2a. Will display or be removed on the application. E-mail delivery will be displayed or removed in this section based on the availability to provide an email policy delivery service.
3. [A. Plan Information Applicant A Applicant B Check the Plan You Prefer……]	Will display on applications used by our Direct-to-Consumer distributions, and will be removed for our Agency and Brokerage distributions. The Medicare supplement plans available will be displayed.
4. [Residence Address: _____ City: _____ ... *etc*]	Will display on applications used by our Agency and Brokerage distributions, and will be removed for our Direct-to-Consumer distributions.
5. [**Go paperless!** To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B....]	Will display or be removed on the application based on the availability of this service.
6. [Refer to the guaranteed issue worksheet to help identify if you are eligible.]	Will display on applications used by our Agency and Brokerage distributions, and will be removed for our Direct-to-Consumer distributions. Open enrollment and guaranteed issue information will be provided in our Direct-to-Consumer marketing material.
7a. [STOP IF EITHER YOU OR APPLICANT B ANSWERED "YES"…..] 7b. [If you are applying during an open enrollment or guaranteed issue period, SKIP SECTIONS G&H and GO TO SECTION I. [Please see enclosed material for explanation of the open enrollment and guaranteed issue periods] [G. Health Information] [H. Medication Information] 7c. (EXCEPTION – If applying for Plan N and replacing a Medicare supplement, Medicare Advantage or employer group health plan, ANSWER ONLY QUESTIONS 10-14.) STOP Do not proceed if applying for Plan N and are replacing other coverage.]	7a. Instructions for the Health and Medication sections will display on all applications except for our Direct-to-Consumer applications marketing individuals in an open enrollment or guaranteed issue period, in which case, the Health and Medication Information sections/instructions will be removed. 7b. Health and Medication sections will display on all applications except for our Direct-to-Consumer applications marketing individuals in an open enrollment or guaranteed issue period, in which case, the Health and Medication Information sections/instructions will be removed. 7c. Will display or remove. We recently changed the level of underwriting for Plan N and will need a few months to evaluate results. We will make a decision about the appropriate level of underwriting to use (current limited underwriting on Plan N, or full underwriting like all other plans) prior to our targeted

	release date (July 1, 2011) for this new application. Under no circumstances will we use these different underwriting options simultaneously.
8. [I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** and an Outline of Coverage.]	Will display on applications used by our Agency and Brokerage distributions, and will be removed for our Direct-to-Consumer distributions.
9a. [Applicant's Signature...*etc.* [Applicant B's Signature...*etc.*] 9b. [Dated at_____,on_____,…*etc.*] City State Month Day	Will display on applications used by our Direct-to-Consumer distributions. Will display on applications used by our Agency and Brokerage distributions.
10. [J. Producer Comments (please attach a separate sheet if needed]	Will display on applications used by our Agency and Brokerage distributions, and will be removed for our Direct-to-Consumer distributions.
11. [K. To be Completed by Producer]	Will display on applications used by our Agency and Brokerage distributions, and will be removed for our Direct-to-Consumer distributions.

Arkansas Insurance Department

Mike Huckabee
Governor

Julie Benafield Bowman
Commissioner

Please read and acknowledge your understanding and assurance of complying with the following requirements:

1. If a sponsor or endorser is involved such as a bank, school, retail store, etc., it must be ascertained whether that sponsor is to receive any form of compensation for the use of the card. If so, this must be disclosed to the insured. If there is compensation, the sponsor would need to be licensed to sell insurance.

2. The company must certify that failure to pay the credit card bill will not affect the premium payment.

3. If the credit card company does not pay the premium for any reason, the insurance company must notify the insured of this and allow a thirty day Grace Period for the insured to pay the premium.

Daniel Kennedy — March 1, 2011

SIGNATURE — DATE

United of Omaha Life Insurance Company

COMPANY

CC-1